CHAPTER 13
ADDENDUM E

DETERMINATION OF PROVIDER - BASED STATUS FOR PAYMENT UNDER OPPS

Note: This reimbursement system is tentatively scheduled to become effective on November 1, 2006.

I. POLICY

The following criteria must be met in order to qualify for provider-based status under the OPPS.

A. An outpatient department, remote location hospital, satellite facility, or provider-based entity must be either created by, or acquired by, a main provider (hospital) for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial administrative control of the main provider, in accordance with the provisions of this addendum in order to qualify for payment under the OPPS. Having clear criteria for provider-based status is important because this designation can result in additional TRICARE payments for services at the provider-based facility (i.e., the incorporation of additional facility costs for covered outpatient services/ procedures).

B. Scope and Definitions.

1. Scope.

a. Provider-based status determinations apply to all hospital outpatient departments, remote location hospitals, and satellite facilities.

b. Provider-based status determinations do not apply for payment purposes to the following facilities:

(1) Ambulatory surgical centers (ASCs).

(2) Comprehensive outpatient rehabilitation facilities (CORFs).

(3) Home health agencies (HHAs).

(4) Skilled nursing facilities (SNFs).

(5) Hospices.

(6) Inpatient rehabilitation units that are excluded from the inpatient PPS for acute hospital services.

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(7) Independent diagnostic testing facilities furnishing only services paid under a fee schedule, such as facilities that furnish only screening mammography services, facilities that furnish only clinical diagnostic laboratory tests, or facilities that furnish only some combination of these services.

(8) Facilities, other than those operating as parts of CAHs, furnishing only physical, occupational, or speech therapy to ambulatory patients.

(9) ESRD facilities.

(10) Departments of providers that perform functions necessary for the successful operation of the providers but do not furnish services of a type for which separate payment could be claimed under TRICARE (for example, laundry or medical records departments).

2. Definitions.

Campus - physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis to be part of the provider's campus.

Department of a provider - A facility or organization that furnishes health care services of the same type as those furnished by the hospital (provider) under its financial and administrative control and ownership. A department of a provider comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under TRICARE, and the personnel and equipment needed to deliver the services at the facility. A department of a provider may not, by itself, be qualified to participate in TRICARE as a provider.

Main provider - A provider that either creates, or acquires, ownership of another entity to deliver additional health care services under its name, ownership, and financial and administrative control.

Provider-based entity - A provider of health care services that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider, in accordance with the provisions of this addendum. A provider-based entity comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the TRICARE program, and the personnel and equipment needed to deliver the services at that facility. A provider-based entity may, by itself, be qualified to participate in TRICARE as a provider, and the TRICARE conditions for participation do apply to a provider-based entity as an independent entity.

Provider-based status - The relationship between a main provider and a provider-

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based entity or a department of a provider, remote location of a hospital, or satellite facility, that complies with the provisions of this addendum.

Remote location of a hospital - A facility or an organization that is either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this addendum. A remote location of a hospital comprises both the specific physical facility that serves as the site of services for which separate payment could be claimed under TRICARE, and the personnel and equipment needed to deliver the services at the facility. The TRICARE conditions of participation do not apply to a remote location of a hospital as an independent entity. The term "remote location of a hospital" does not include a satellite facility.

C. Requirements to Gain Provider-Based Status for Payment Under OPPS. Any facility or organization for which provider-based status is sought, whether located on or off the campus of a potential main provider, must meet all of the following requirements to be determined to have provider-based status:

1. Licensure - The department of the provider, the remote location of a hospital, or the satellite facility and the main provider are operated under the same license, except in areas where the State requires a separate license for the department of the provider, the remote location of a hospital, or the satellite facility, or in States where State law does not permit licensure of the provider and the prospective department of the provider, the remote location of a hospital, or the satellite facility under a single license. If a State health facilities' cost review commission, or other agency that has authority to regulate the rates charged by hospitals or other providers in a State, finds that a particular facility or organization is not part of a provider, it will be determined that the facility or organization does not have provider-based status.

2. Clinical services - The clinical services of the facility or organization seeking provider-based status and the main provider are integrated as evidenced by the following:

a. Professional staff of the facility or organization have clinical privileges at the main provider.

b. The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

c. The medical director of the facility or organization seeking provider-based status maintains a reporting relationship with the chief medical officer or other similar official of the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the main provider and the chief medical officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

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d. Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

e. Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

f. Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

3. Financial integration. The financial operation of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization.

4. Public awareness. The facility or organization seeking status as a department of a provider, a remote location of a hospital, or a satellite facility is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.

5. Obligations of hospital outpatient departments and hospital-based entities. In the case of a hospital outpatient department or a hospital-based entity, the facility or organization must fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph I.F.

D. Additional requirements applicable to off-campus facilities or organizations. Any facility or organization for which provider-based status is sought that is not located on the campus of a potential main provider must meet both the requirements in paragraph I.C. and all of the following additional requirements, in order to be determined to have provider-based status.

1. Operation under the ownership and control of the main provider. The facility or organization seeking provider-based status is operated under the ownership and control of the main provider, as evidenced by the following:

a. The business enterprise that constitutes the facility or organization is 100 percent owned by the provider.

b. The main provider and the facility or organization seeking status as a department of the provider, a remote location of a hospital, or a satellite facility have the same governing body.

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c. The facility or organization is operated under the same organizational documents as the main provider. For example, the facility or organization seeking provider-based status must be subject to common bylaws and operating decisions of the governing body of the provider where it is based.

d. The main provider has final responsibility for administration decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits or code of conduct), and final approval for medical staff appointments in the facility or organization.

2. Administration and supervision. The reporting relationship between the facility or organization seeking provider-based status and the main provider must have the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its existing departments, as evidenced by compliance with all of the following requirements:

a. The facility or organization is under the direct supervision of the main provider.

b. The facility or organization is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability. The facility or organization director or individual responsible for daily operations at the entity:

(1) Maintains a reporting relationship with a manager at the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and its existing departments; and

(2) Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.

c. The following administrative functions of the facility or organization are integrated with those of the provider where the facility or organization is based: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are:

(1) Contracted out under the same contract agreement; or

(2) Handled under different contract agreements, with the contract of the facility or organization being managed by the main provider.

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3. Location in immediate vicinity. The facility or organization is on the campus, except when the requirements in paragraph I.D.3.a., b. or c. are met:

a. The facility or organization is located within a 35-mile radius of the main campus of the hospital or CAH that is the potential main provider;

b. The facility or organization is owned and operated by a hospital or CAH that has a disproportionate share adjustment greater than 11.75 percent and is:

(1) Owned or operated by a unit of local government;

(2) A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or

(3) A private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan).

c. The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed and for each subsequent 12-month period:

(1) At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider;

(2) At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider); or

(3) If the facility or organization is unable to meet the criteria in paragraph I.D.3.c.(1) or (2) because it was not in operation during all of the 12-month period described in the previous sentence, the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in the previous sentence, accounted for at least 75 percent of the patients served by the main provider.

d. A facility or organization is not considered in the "immediate vicinity" of the main provider unless the facility or organization and the main provider are located in the same State or, when consistent with the laws of both States, or adjacent States.

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e. An RHC that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area and has fewer than 50 beds is not subject to the criteria in paragraph I.D.3.a. through d.

E. Provider-based status for joint ventures. In order for a facility or organization operated as a joint venture to be considered provider-based, the facility or organization must:

1. Be partially owned by at least one provider;

2. Be located on the main campus of a provider who is a partial owner;

3. Be provider-based to that one provider on whose campus the facility or organization is located; and

4. Also meet all the requirements applicable to all provider-based facilities and organizations in paragraph I.C. For example, where a provider has jointly purchased or jointly created a facility under joint venture arrangements with one or more other providers, and the facility is not located on the campus of the provider or the campus of any other provider engaged in the joint venture arrangement, no party to the joint venture arrangement can claim the facility as provider-based.

F. Obligations of hospital outpatient departments and hospital-based entities. To qualify for provider-based status in relation to a hospital, a facility or organization must comply with the following requirements:

1. The following departments must comply with anti-dumping rules [42 CFR §489.20(l), (m), (q), and (r) and §489.24]:

a. Any facility or organization that is located on the main hospital campus and is treated under this addendum as a department of the hospital; and

b. Any facility or organization that is located off the main hospital campus that is treated under this addendum as a department of the hospital and is a dedicated emergency department.

2. Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) must be billed with the correct site-of-service so that appropriate physician and practitioner payment amounts can be determined.

3. Hospital outpatient departments must comply with all the terms of the hospital's provider agreement.

4. Physicians who work in hospital outpatient departments or hospital-based entities are obligated to comply with the non-discrimination provision (42 CFR §489.10(b)).

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5. Hospital outpatient departments (other than RHCs) must treat all Medicare/ TRICARE patients, for billing purposes, as hospital outpatients. The department must not treat some patients as hospital outpatients and others as physician office patients.

6. In the case of a patient admitted to the hospital as an inpatient after receiving treatment in the hospital outpatient department or hospital-based entity, payments for services in the hospital outpatient department or hospital-based entity are subject to the payment window provisions applicable to PPS hospitals and to hospitals and units excluded from PPS.

7. When a beneficiary is treated in a hospital outpatient department or hospital-based entity (other than a RHC) that is not located on the main provider's campus, the hospital must provide written notice to the beneficiary, before the delivery of services, of the amount of the beneficiary's potential financial liability (that is, that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of the liability). The notice must be one that the beneficiary can read and understand. If the exact type and extent of care needed is not known, the hospital may furnish a written notice to the patient that explains that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based. The hospital may furnish an estimate based on typical or average charges for visits to the facility, while stating that the patient's actual liability will depend upon the actual services furnished by the hospital. If the beneficiary is unconscious, under great duress, or for any reason unable to read a written notice and understand and act on his or her own behalf, the notice must be provided, before delivery of services, to the beneficiary's authorized representative.

8. Hospital outpatient departments must meet applicable hospital and safety rules for participating hospitals.

G. Management contracts. A facility or organization that is not located on the campus of the potential main provider and otherwise meets the requirements of paragraph I.C. and D., but is operated under management contracts, must also meet all of the following criteria:

1. The main provider (or an organization that also employs the staff of the main provider and that is not the management company) employs the staff of the facility or organization who are directly involved in the delivery of patient care, except for management staff and staff who furnish patient care services of a type that would be paid for under a fee schedule established by regulations. Other than staff that may be paid under such a fee schedule, the main provider may not utilize the services of "leased" employees (that is, personnel who are actually employed by the management company but provide services for the provider under a staff leasing or similar agreement) that are directly involved in the delivery of patient care.

2. The administrative functions of the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph I.D.2.c.

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3. The main provider has significant control over the operations of the facility or organization as determined under criteria in paragraph I.D.2.b.

4. The management contract is held by the main provider itself, not by a parent organization that has control over both the main provider and the facility or organization.

H. Inappropriate treatment of a facility or organization as provider-based.

1. Determination and review. If it is learned that a provider has treated a facility or organization as provider-based, and the provider has not obtained a determination of provider-based status under this addendum, the following action will be taken:

a. Issue notice to the provider in accordance with paragraph I.H.3., adjust the amount of future payments to the provider for service of the facility or organization in accordance with paragraph I.H.4., and continue payment to the provider for services of the facility or organization only in accordance with paragraph I.H.5.; and

b. Investigate and determine whether the requirements in paragraph I.C. were met; and

c. Review all previous payments to that provider for all cost reporting periods subject to re-opening.

2. Recovery of overpayments. If it is found that payments for services at the facility or organization were made as if the facility or organization were provider-based, even though there had not been a previous determination that the facility or organization qualified for provider-based status:

a. The difference between the amount of payments that actually were made and the estimated amount of payments that would have been made in the absence of a determination of provider-based status would be recovered.

b. Recovery payments will not be initiated for any period before the beginning of the hospital's first cost reporting period beginning on or after January 10, 2001, if during all of that period the management of the entity made a good faith effort to operate it as a provider-based facility or organization.

3. Notice to provider. If it is determined that a facility or organization was inappropriately treated as provider-based, a written notice will be issued to the provider that payments for past cost reporting periods may be reviewed and recovered as described in paragraph I.H.1.c., and that future payments for services in or of the facility or organization will be adjusted as described in paragraph I.H.4.

4. Adjustment of payments. If it is determined that a facility or organization was inappropriately treated as provider-based, future payments will be adjusted to the provider

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or the facility or organization, or both, to the estimated amounts that would be paid for the same services furnished by a freestanding facility.

5. Continuation of payment

a. The notice of denial of provider-based status sent to the provider will ask the provider for notification in writing, within 30 days of the date the notice is issued, of whether the provider intends to seek a determination of provider-based status for the facility or organization under this addendum or whether the facility or organization (or, where applicable, the practitioners who staff the facility or organization) will be seeking to enroll and meet other requirements to bill for services in a freestanding facility.

b. If the provider indicates that it will not be seeking a determination for the facility or organization under this addendum or that the facility or organization or its practitioners will not be seeking to enroll, or if a response is not received within 30 days of the date the notice was issued, all payments under paragraph I.H.5. will end as of the 30th day after the date of notice.

c. If the provider indicates that it will be seeking a determination for the facility or organization under this addendum, or that the facility or organization or its practitioners will be seeking to meet enrollment and other requirements for billing for services in a freestanding facility, payment for services of the facility or organization will continue at the adjusted amounts described in paragraph I.H.4. for as long as is required for all billing requirements to be met (but not longer than 6 months) if the provider or the facility or organization or its practitioners:

(1) Submits, as applicable, a complete request for a determination of provider-based status or a complete enrollment application and provides all other required information within 90 days after the date of notice; and

(2) Furnishes all other information needed to make a determination regarding provider-based status or process the enrollment application, as applicable, and verifies that other billing requirements are met.

d. If the necessary applications or information are not provided, all payments to the provider, facility, or organization will be terminated as of the date the notice was issued that necessary application or information had not been submitted.

I. Temporary treatment as provider-based.

If a provider submits a complete attestation of compliance with the requirements for provider-based status for a facility or organization that has not previously been inappropriately treated as provider-based under paragraph I.H., the provider may bill and be paid for services of the facility or organization as provider-based from the date it submits the attestation and any required supporting documentation until the date that it is determined that the facility or organization does not meet the provider-based rules. If it is

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subsequently determined that the requirements for provider-based status are not met, the difference between the amount of payments that actually was made since the date the complete attestation of compliance with provider-based requirements was submitted, and the amount of estimated payments that should have been made in the absence of compliance with the provider-based requirements, will be recovered.

J. Correction of errors.

1. If it is determined that a facility or organization that had previously been determined to be provider-based under this addendum no longer qualifies for provider-based status, and the failure to qualify for provider-based status resulted from a material change in the relationship between the provider and the facility or organization that was not reported, treatment of the facility or organization as provider based ceases with the date that it is determined that the facility or organization no longer qualifies for provider-based status.

2. If it is determined that a facility or organization that had previously been determined to be provider-based under this addendum no longer qualifies for provider-based status, and if the failure to qualify for provider-based status resulted from a material change in the relationship between the provider and the facility or organization that the provider did not report, actions will be taken with respect to notice to the provider, adjustment of payments, continuation of payments, and potential recovery of past payments.

K. Status of Indian Health Service and Tribal facilities and organizations. Facilities and organization operated by the Indian Health Services or Tribes will be considered to be department of hospitals operated by the Indian Health Services or Tribes if, on or before April 7, 2000, they furnished only services that were billed as if they had been furnished by a department of a hospital operated by the Indian Health Services or a Tribe and they are:

1. Owned and operated by the Indian Health Service;

2. Owned by the Tribe but leased from the Tribe by the HIS under the Indian Self-Determination Act (Pub. L. 93-638) in accordance with applicable regulations and policies of the Indian Health Service in consultation with Tribes; or

3. Owned by the Indian Health Service but leased and operated by the Tribe under the Indian Self-Determination Act (Pub. L. 93-638) in accordance with applicable regulations and policies of the Indian Health Service in consultation with Tribes.

L. FQHCs and "look-a-likes". A facility that has, since April 7, 1995, furnished only services that were billed as if they had been furnished by a department of a provider will continue to be treated, for purposes of this addendum, as a department of the provider without regard to whether it complies with the criteria for provider-based status in the addendum, if the facility:

1. Received a grant on or before April 7, 2000 under Section of the Public Health Service Act and continues to receive funding under such a grant, or is receiving funding from

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a grant made on or before April 7, 2000 under Section 330 of the Public Health Service Act under a contract with the recipient of such a grant, and continues to meet the requirements to receive a grant under Section 330 of the Public Health Service Act; or

2. Based on the recommendation of the Public Health Service, was determined on or before April 7, 2000 to meet the requirements for receiving a grant under Section 330 of the Public Health Service Act, and continues to meet such requirements.

M. Effective date of provider-based status

1. General rule. Provider-based status for a facility or organization is effective on the earliest date all of the requirements of this addendum have been met.

2. Inappropriate treatment as provider-based or not reporting material change. If a facility or organization is found to have been inappropriately treated as provider-based under paragraph I.H., or was previously determined to be provider-based but no longer qualifies as provider-based because of a material change that was not reported, the facility or organization will not be treated as provider-based for payment purposes until it has been determined, based on documentation submitted by the provider, that the facility or organization meets all requirement for provider-based status under this part.

N. Procedure for obtaining provider-based determinations

1. A facility or organization is not entitled to be treated as provider-based simply because it or the main provider believe it is provider-based.

2. If a potential main provider seeks a determination of provider-based status for a facility that is located on the campus of the potential main provider, the provider would be required to submit an attestation stating that the facility meets the criteria in paragraph I.C. and, if it is a hospital, also attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph I.F. The provider seeking such a determination would also be required to maintain documentation of the basis for its attestations and to make that documentation available upon request.

3. If the facility is not located on the campus of the potential main provider, the provider seeking determination would be required to submit an attestation stating that the facility meets the criteria in paragraph I.C. and D., and if the facility is operated as a joint venture or under a management contract, that the facility also meets the requirements of paragraph I.E. or paragraph I.G., as applicable. If the potential main provider is a hospital, the hospital also would be required to attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph I.F. The provider would be required to supply documentation of the basis for its attestations at the time it submits its attestations.

4. Whenever a provider submits an attestation of provider-based status for an on- or off-campus facility or organization, it will be sent a written acknowledgement of receipt of

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the attestation. The attestation will be reviewed for completeness and consistency with criteria in this addendum, and consistency with information on hand at the time the attestation is received. A determination will be made base on this review as to whether the facility or organization is provider-based.

5. A facility that is not located on the campus of a hospital and that is providing services of the kind ordinarily furnished in physician offices will be presumed as a free-standing facility, unless it is determined that the facility has provider status.

6. A main provider must report any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that would affect the provider-based status of the facility or organization.

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